STATE OF TENNESSEE
DEPARTMENT OF HEALTH
BUREAU OF HEALTH LICENSURE AND REGULATION
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METROCENTER
NASHVILLE, TN 37243
www.Tennessee.gov/health

INSTRUCTIONS FOR LICENSURE AS A PODIATRIST
(615)532-5088, or (800)778-4123

The enclosed application and instructions are pertinent for those podiatrists who are applying for licensure based on examination or reciprocity or for an academic license.

Please carefully read the information below to determine the method of licensure for which you will be applying and follow the instructions for the selected method. The requirements for application are supported by T.C.A. Sections 63-3-101 through 63-3-125, T.C.A. Sections 63-1-101 through 63-1-138 and Rules and Regulations Chapters 1155-2-.01 through 1155-2-.09, which are included with the application packet.

It is suggested all documents listed in the instructions be requested from the appropriate institutions or individuals upon receipt of this package. All supporting documents must be received in the Board's administrative office by the time frames indicated in the instructions. Please allow ten (10) working days for the information submitted to be received and placed in your file. Mail delivered by Federal Express and other special courier services will be handled as routine mail.

METHODS OF LICENSURE

ACADEMIC - The licensure method for individuals who have met all requirements for full and unrestricted Podiatry licensure except for post graduate training and/or licensing examinations. This license allows a Podiatrist to enter into an internship or preceptorship. If you wish to apply for an Academic License go to Section III for the appropriate instructions.

EXAMINATION - The licensure method for individuals who have received the degree of Doctor of Podiatric Medicine and who have successfully completed the National Board Examination and who have completed an internship, preceptorship, have served three (3) years as a Podiatrist in any branch of the United States' armed services or has been licensed and practiced in another state for at least ten (10) years. If you wish to apply for licensure by examination go to Section I for the appropriate instructions.

RECIPROCITY - The licensure method for Podiatrists who hold a current and valid license in another state provided the license requirements in the other state are substantially the same as those required in Tennessee. If you wish to apply for licensure by reciprocity go to Section II for the appropriate instructions.

SECTION I - Instructions for licensure by Examination

The following items must be submitted to the Board Office no later than sixty (60) days prior to the next scheduled examination.

1. Completed and notarized application indicating method of requested licensure.

2. To apply by exam, or reciprocity an application fee of four hundred and forty dollars ($440) and a state regulatory fee of ten dollars ($10) is needed for a total of ($450).

3. Two (2) recent full face photographs taken within the last twelve (12) months, which are signed and notarized. The notary seal must be on the pictures.

4. Official transcript sent directly to the Board Office from the school of Podiatry from which you graduated. The transcript must indicate date graduated and degree awarded.

5. An applicant shall submit evidence of good moral character. Such evidence shall be three (3) recent (within the preceding 12 months) original letters, two of which must be from licensed podiatrist, medical doctors or osteopathic physicians attesting to the applicant's personal character and professional ethics on the signator's letterhead.

6. An applicant shall submit proof of being eighteen (18) years of age or older. Acceptable proof is a certified/notarized copy of the applicant's birth certificate, drivers license, or voters registration card.

7 Verification of successful completion of Parts I and II of the National Board Examination sent directly from the National Board to the Tennessee Board's office.

8 Verification of successful completion of one of the following:

Use Attachment 1

a. One (1) year Approved Residency program - The CERTIFICATE OF COMPLETION OF APPROVED RESIDENCY/PRECEPTORSHIP TRAINING form must be completed and forwarded to the Board's office.

b. Two (2) year Approved Preceptor Program - The CERTIFICATE OF COMPLETION OF AN APPROVED RESIDENCY/PRECEPTOR TRAINING form must be completed and forwarded to the Board's office.

c. Three (3) years active service practicing as a Podiatrist in the U.S. Armed Services. A letter from the Branch of Services verifying the above must be submitted.

9 Verification the Residency or Preceptor program was approved by an accrediting agency:

Use Attachment 2

a. RESIDENCY PROGRAM - The AFFIDAVIT OF ACCREDITATION OF RESIDENCY PROGRAM - complete Section I and forward it along with a Fifteen Dollar ($15) fee to the American Podiatric Medical Association at the address listed on the form.

b. PRECEPTORSHIP PROGRAM - The AFFIDAVIT OF ACCREDITATION OF PRECEPTORSHIP PROGRAM Form - complete Section I and send to the college or university providing accreditation for verification.

10. Clearance from the Federation of Podiatric Medical Examiners sent directly from the Federation to the Tennessee Board office. Complete The FEDERATION OF PODIATRIC MEDICAL BAORDS REPORT FOR DISCIPLINARY INQUIRIES form and forward it along with a FORTY DOLLAR ($40) fee to the Federation at the address listed on the form.

Use Attachment 4

11. Verification of licensure – Complete the top portion of the VERIFICATION OF LICENSURE form and send it to all states in which you hold a current license or have ever held a license. This form should be photocopied prior to signing it if it must be submitted to more than one (1) state.

Use Attachment 5

12. Verification of successful completion of the PMLexis Examination if taken in another state Complete the FEDERATION OF PODIATRIC MEDICAL BOARDS REQUEST FOR PMLEXIS CERTIFIED SCORE REPORT and forward it along with a Thirty-Five Dollar ($35) fee to the Federation at the address listed on the form.

Please note that as of July 17, 2006 Criminal Background checks are required. Click here for instructions.

A completed application file is required sixty (60) days in advance of when you wish to take the PMLexis Examination.

A completed file is one which contains ALL of the required documentation.

Applicants will be notified when they have been approved for the written and/or oral.

RE-EXAMINATION

Those applicants who do not pass the examination must notify the Board in writing of their intent to retake the examination.

SECTION II - Instructions for licensure by Reciprocity

The following items must be submitted to the Board Office no later than thirty (30) days prior to the next scheduled Board meeting.

1. Completed and notarized application indicating method of requested licensure.

2. To apply by exam, or reciprocity an application fee of four hundred and forty dollars ($440) and a state regulatory fee of ten dollars ($10) is needed for a total of ($450).

3. One (1) recent full face photograph taken within the last twelve (12) months, which is signed and notarized. The notary seal must be on the picture.

4. Official transcript sent directly to the Board office from the school of Podiatry from which you graduated. The transcript must indicate date graduated and degree awarded.

5. An applicant shall submit evidence of good moral character. Such evidence shall be three (3) recent (within the preceding 12 months) original letters, two of which must be from licensed podiatrist, medical doctors or osteopathic physicians attesting to the applicant's personal character and professional ethics on the signator's letterhead.

6. An applicant shall submit proof of being eighteen (18) years of age or older. Acceptable proof is a certified/notarized copy of the applicant's birth certificate, drivers license, or voters registration card.

7 Verification of successful completion of Parts I and II of the National Board Examination sent directly from the National Board to the Tennessee Board's office.

8 Verification of successful completion of one of the following:

USE ATTACHMENT 1

a. One (1) year Approved Residency program - The CERTIFICATE OF COMPLETION OF APPROVED RESIDENCY TRAINING form must be completed and forwarded to the Board's office.

b. Two (2) year Approved Preceptorship Program - The CERTIFICATE OF COMPLETION OF AN APPROVED PRECEPTORSHIP TRAINING form must be completed and forwarded to the Board's office.

c. Three (3) years active service practicing as a Podiatrist in the U.S. Armed Services. A letter from the Branch of Services. A letter from the Branch of Services verifying the above must be submitted.

9 Verification that Residency or Preceptorship program was approved by an accrediting agency:

USE ATTACHMENT 2

a. RESIDENCY PROGRAM - The AFFIDAVIT OF ACCREDITATION OF RESIDENCY PROGRAM FORM - complete Section I and forward it along with a Fifteen Dollar ($15) fee to the American Podiatric Medical Association at the address listed on the form.

USE ATTACHMENT 6

b. PRECEPTORSHIP PROGRAM - The AFFIDAVIT OF ACCREDITATION OF PRECEPTORSHIP PROGRAM Form - complete Section I and send to the college or university providing accreditation for verification.

USE ATTACHMENT 3

10 Clearance from the Federation of Podiatric Medical Boards sent directly from the Federation to the Tennessee Board office. Complete the FEDERATION OF PODIATRIC MEDICAL BOARDS REPORT FOR DISCIPLINARY INQUIRIES Form and forward it along with forty dollar ($40) fee to the Federation at the address listed on the form.

USE ATTACHMENT 5

11 Verification of successful completion of the PMLexis Examination if taken in another state. Complete the FEDERATION OF PODIATRIC MEDICAL BOARDS REQUEST FOR PMLEXIS CERTIFIED SCORE REPORT and forward it along with thirty five dollar ($35) fee to the Federation at the address listed on the form.

USE ATTACHMENT 4

12 Verification of Licensure – Complete the top portion of the VEIFICATION OF LICENSURE Form and send it to all states in which you hold a current license or have ever held a license. This form should be photocopied prior to signing it, if it must be submitted to more than one state.

Please note that as of July 17, 2006 Criminal Background checks are required. Click here for instructions.

A completed file is one which contains ALL of the required documentation.

You are required to appear before the Board for an interview and pass an oral examination administered by the Board. You will be notified in writing of the date, time, and place of the next regularly scheduled Board meeting for this interview and examination.

SECTION III - Instructions for an Academic license

The following items must be submitted to the Board office no later than fourteen (14) days prior to the next scheduled Board meeting.

1. Completed and notarized application indicating method of requested licensure.
2. Fees:

   To apply for an academic license a fee of four hundred and forty dollars ($440) and a state regulatory fee of ten dollars ($10) is needed for a total of ($450).

3. One (1) recent full face photograph taken within the last twelve (12) months, which is signed and notarized. The notary seal must be on the picture.

   a. Official transcript sent directly to the Board office from the school of Podiatry from which you graduated. The transcript must indicate date graduated and degree awarded.

5. An applicant shall submit evidence of good moral character. Such evidence shall be three (3) recent (within the preceding 12 months) original letters, two of which must be from licensed podiatrist, medical doctors or osteopathic physicians attesting to the applicant's personal character and professional ethics on the signator's letterhead.

6. An applicant shall submit proof of being eighteen (18) years of age or older. Acceptable proof is a certified/notarized copy of the applicant's birth certificate, drivers license, or voters registration card.

7 Verification of successful completion of Parts I and II of the National Board Examination sent directly from the National Board to the Tennessee Board's office.

USE ATTACHMENT 7

8 Verification of enrollment in an approved Residency or Preceptorship program. The enclosed AFFIDAVIT OF ENROLLMENT IN RESIDENCY OR PRECEPTORSHIP PROGRAM form must be completed by the director of the program and returned to the Board office.

9 Verification the Residency or Preceptorship program is approved by an accrediting agency:

USE ATTACHMENT 2

a. RESIDENCY PROGRAM - The AFFIDAVIT OF ACCREDITATION OF RESIDENCY PROGRAM - complete Section I and forward it along with a Fifteen Dollar ($15) fee to the American Podiatric Medical Association at the address listed on the form.

USE ATTACHMENT 6

b. PRECEPTORSHIP PROGRAM - The AFFIDAVIT OF ACCREDITATION OF PRECEPTORSHIP PROGRAM form - complete Section I and send to the college or university providing accreditation for verification.

USE ATTACHMENT 3

10 Clearance from the Federation of Podiatric Medical Bopards sent directley from the Federation the Tennessee Board office. Complete the FEDERATION OF PODIATRIC MEDICAL BOARDS REPORT FOR DISCIPLINARY INQUIRIES form and forward it along with a Forty Dollar ($40) fee to the Federation at the address listed on the form.

Please note that as of July 17, 2006 Criminal Background checks are required. Click here for instructions.

A completed file is one which contains ALL of the required documentation.

All files completed fourteen (14) days prior to a regularly scheduled Board meeting will be presented to the Board for review at that meeting.

ATTACH PHOTO HERE

ATTACH PHOTO HERE

Academic Rec/Exam

For office use only
2215) 001 $ 440
2215) 001 $ 440
2215) 006 $ 10

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

Exam-2 photos required

STATE OF TENNESSEE
BOARD OF PODIATRIC MEDICAL EXAMINERS

APPLICATION FOR REGISTRATION AS A PODIATRIST
(Must Type)

NOTE: ALL INFORMATION IN LICENSURE FILES ARE OPEN FOR PUBLIC INSPECTION PURSUANT TO TCA §10-7-503.

PLEASE CHECK ONE: _____ Examination _____ Reciprocity _____ Academic

FULL NAME: _____
(Last) (First) (Middle) (Maiden)

MAILING ADDRESS: _____
(Street and Number)

_____
(City) (State) (Zip) (TN-County)

PHONE NUMBER: Home ( )_____ Work ( )_____

PLACE OF BIRTH: _____ DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____ SEX: M ___ F ___

PRACTICE ADDRESS IN TENNESSEE: _____
_____

PREMEDICAL EDUCATION

	NAME OF SCHOOL	DATES ATTENDED	DEGREE
A.			
B.			
C.			

PODIATRY EDUCATION

1st year Name _____
Address _____
Dates _____

2nd year Name _____
Address _____
Dates _____

3rd year Name _____
Address _____
Dates _____

4th year Name _____
Address _____
Dates _____

POST GRADUATE STUDY OR WORK

Are you currently enrolled in a Residency/Preceptorship program? Yes____ No___

If yes; Name of residency/preceptorship: _____

Address: _____

_____

Director: _____

Following completion of your residency/preceptor program, do you plan to practice in Tennessee? Yes___ No___

Have you completed:

A one (1) year residency? Yes___ No___

A two (2) year preceptorship? Yes___ No___

Three (3) years of active duty with a branch of this country's armed services as podiatric physician? Yes___ No___

*Ten (10) years of practice as a podiatrist in another state prior to 1990? Yes___ No___

*If yes, please explain fully on a separate sheet.

Have you taken the National Board Examination?

Part I YES___ NO___

Part II YES___ NO___

Have you ever taken a podiatry licensing examination in another state? Yes___ No___

If YES what state(s) _____

If YES was it: A state exam _____ Pass _____ Fail _____

PMLexis _____ Pass _____ Fail _____

Other _____ Pass _____ Fail _____

Explain: _____

_____

(Have verification of your scores sent directly to the Board)

List below states in which you have ever been or are currently licensed as a podiatrist.

STATE LICENSED	LICENSE NUMBER	DATE ISSUED

List below states in which you hold a license as a health professional other than a Podiatrist.

STATE LICENSED	LICENSE NUMBER	DATE ISSUED

(Have "Verification of Licensure" form completed and sent directly to this board from each state in which you now hold or have ever held licensure.)

PLEASE ANSWER THE FOLLOWING QUESTIONS. If any answers are in the affirmative with the exception of question number 1, please explain in detail on an attached sheet. In support of your explanation, the final documents or Orders from the states, courts, and agencies must be submitted as a part of your file.

		YES	NO
1.	Are you now in good physical and mental health?		
2.	Are you currently taking any medications requiring a prescription?		
3.	Has your certificate or license to practice Podiatry in any state ever been reprimanded, suspended, restricted, revoked, otherwise disciplined, curtailed, voluntarily surrendered, under threat of investigation or disciplinary action?		
4.	Have your staff privileges at any hospital or health care facility ever been revoked, suspended, curtailed, restricted, limited, otherwise disciplined, voluntarily surrendered, under threat of restriction or disciplinary action?		
5.	Have you ever been denied a state or federal controlled substances certificate?		
6.	Has your state or federal controlled substances certificate ever been revoked, suspended, restricted, otherwise disciplined, voluntarily surrendered, under threat of investigation or disciplinary action?		

		YES	NO
7.	Do you have a medical condition which in any way impairs or limits your ability to practice podiatric medicine with reasonable skill and safety? If yes, please explain.	_____	_____
8.	If you use chemical substance(s) do they in any way impair or limit your ability to practice podiatric medicine with reasonable skill and safety? If yes, please explain.	_____	_____
9.	If you have any limitations or impairments caused by an existing medical condition are they reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.	_____	_____
10.	If you have any limitations or impairments caused by an existing medical condition are they reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.	_____	_____
11.	Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism? If yes, please explain.	_____	_____
12.	Are you currently engaged in the illegal use of controlled dangerous substances? If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled substances?	_____	_____
13.	Have you ever been convicted of a felony or a misdemeanor other than a minor traffic violation?	_____	_____
14.	Have you ever been rejected or censured by a professional society?	_____	_____
15.	Have you ever had a judgment rendered against you, or any legal action settled or pending, relating to the performance of your professional service?	_____	_____
16.	Have you ever applied for a professional license in any health care profession and been denied or restricted for any reason?	_____	_____

Before signing this application, please read it again to make sure you have answered all questions accurately, completely, and clearly. Use additional sheets whenever necessary.

THIS APPLICATION MUST BE NOTARIZED

I, _____, solemnly swear that the statements on this application are true and correct. In signing this, I am aware that Chapter 9, Public Acts of 1947, provides that a person filing a forged Affidavit of Identification is subject to punishment prescribed by law for the crime of forgery.

I HEREBY:

SIGNIFY MY WILLINGNESS to appear to answer such questions as the Board may find necessary, which may include a full Board interview.

AUTHORIZE THE BOARD, its staff, and their representatives to consult with my prior and current associates and others who may have information bearing on my professional competence, character, health status, ethical qualifications, ability to work cooperatively with others, and other qualifications.

CONSENT TO THE RELEASE of such information.

RELEASE FROM LIABILITY the board, its staff, and all their representatives for their acts performed and statements made in good faith and without malice in connection with evaluating my application, my credentials, and my qualifications.

RELEASE FROM LIABILITY any and all organizations which provide information in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for licensure.

ACKNOWLEDGE THAT I, as an applicant for licensure, have the burden of producing adequate information for a proper evaluation of my professional, ethical, other qualifications, and for resolving any doubts about such qualifications.

_____
Signature of applicant

(notary seal)

Subscribed and sworn before me this _____ day of _____, _____ A.D. at

_____
(City or Place) (State)

_____
Notary Public

My commission expires _____.

ATTACHMENT 1

(Check one only)

A ___ One Year
B ___ Two Year

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

CERTIFICATE OF COMPLETION OF APPROVED RESIDENCY/PRECEPTORSHIP TRAINING

This is to certify that _____, a participant of
Applicant's name
_____, participated in an approved residency/preceptorship program
Name of Program
offered by _____
Name and Address of Facility
from _____ thru _____ and that the above named participant successfully completed this
Date Date
program on _____.
Date

_____, being duly sworn, says he/she is/was the program director for the participant named above during the program indicated and that he/she has carefully read and completed this form and that the statements made herein are strictly true in every respect.

_____
Type or Print Name of Program Director

_____

_____
Address

Phone Number ( ) _____

_____
Signature of Program Director

Signed and sworn to before me this ____ day of _____, _____.

Notary Seal

_____
Notary Public

My commission expires _____.

NOTE: Approved podiatric residencies are those programs approved by the Council on Podiatric Medical Education.

Approved podiatric preceptorships are those programs approved by a College of Podiatric Medicine.

ATTACHMENT 2

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

AFFIDAVIT OF ACCREDITATION OF RESIDENCY PROGRAM

If you have completed an approved Residency program, Please complete Section I and send this form along with a Fifteen Dollar ($15) fee to the AMERICAN PODIATRIC MEDICAL ASSOCIATION for verification of an approved Residency, at the following location:

American Podiatric Medical Association, Inc.
9312 Old Georgetown Road
Bethesda, MD 20814
(301) 571-9200 or
1-800-ASK-APMA

SECTION I

Name of Applicant

Name of Residency Program

Date of Residency

Address of Residency Program

Director of Residency Program

SECTION II - THIS SECTION MUST BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE OF THE AMERICAN PODIATRIC MEDICAL ASSOCIATION.

This will verify that the above named Residency Program has been granted full accreditation by the American Podiatric Medical Association.

Name - Please Print or Type

NOTARY

SEAL

Signature

Title

Date

Subscribed and sworn before me this _____ day of _____, 20 _____.

(Notary Seal)

Notary

My commission expires _____

Please return to: Address listed above

ATTACHMENT 3

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

FEDERATION OF PODIATRIC MEDICAL BOARDS
REPORT FOR DISCIPLINARY INQUIRIES

INSTRUCTIONS: All Part III score and disciplinary reports should be ordered at the FPMB web site at www.fpmb.org. Simply press the "order reports" button. After filling out an online form, visitors have the option to immediately pay for requests with their Visa or Master Card credit card. **Alternatively, requests may be printed and mailed to the Federation of Podiatric Medical Boards with a check.**

DISCIPLINARY INQUIRIES
The new FPMB mailing address is:
Larry Shane, Executive Director
Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, FL 33437
(561) 752-3735
(DPM)

The TENNESSEE BOARD OF PODIATRIC MEDICAL EXAMINERS requests a disciplinary search concerning the following applicant:

NAME: _____
Last First Middle Maiden

ADDRESS _____

_____
City State Zip Code

DATE OF BIRTH _____ SOCIAL SECURITY # _____

PODIATRY SCHOOL _____ DATE OF GRADUATION _____

SCHOOL LOCATION _____

FEDERATION: PLEASE MAIL REPORT DIRECTLY TO: ADDRESS LISTED ABOVE

ATTACHMENT 4

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place Metrocenter
Nashville, TN 37243

VERIFICATION OF LICENSURE

Please complete the TOP portion and forward one (1) form to the Board of Podiatry in EACH state where you hold or have held a license to practice. (If you need more forms, make copies of this one)

NOTE: Some states require a fee be paid for providing clearance information. In order to expedite your application, you may wish to contact the applicable state or states.

_____ was granted _____ on _____
Name of Applicant License Number Date

by the state of _____. The Tennessee Board of Podiatric Medical Examiners requests that I submit evidence that my license in your state is in good standing. You are hereby authorized to release any information in your files, favorable or otherwise, directly to:

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

Your early attention is appreciated.

DATE: _____ _____
Signature

_____
Typed or printed name

ADMINISTRATIVE OFFICE OF STATE PODIATRY BOARD
PLEASE COMPLETE:

License Number _____ Date issued _____

Basis of issuance: National Board Exam
State Exam _____ Score _____
PMLexis Exam _____ Score _____
Other _____ Explain: _____

License currently registered? Yes ___ No ___
Derogatory information on file? Yes ___ No ___

NOTARY SEAL

If derogatory information in file please attach explanation, final orders, etc.

Subscribed and sworn before me this _____ day of _____, 20 _____.
(Notary Seal)

_____
Notary

_____ _____ _____
Authorized Signature Title Date

ATTACHMENT 5

Tennessee Board of Podiatric Medical Examiners
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

FEDERATION OF PODIATRIC MEDICAL BOARDS

REQUEST FOR PMLEXIS CERTIFIED SCORE REPORT

INSTURCTIONS: Applicants for licensure who (1) have already taken the PMLexis in another state, AND (2) whose score has been reported to that state's licensing board may, by completing this form AND including certified funds in the amount of Thirty-Five Dollars ($35) payable to FPMB may request that the Federation certify that score to another state board. The Thirty-Five Dollar ($35) fee applies to each score report to every additional (second, third, etc.) state board.

All Part III score and disciplinary reports should be ordered at the FPMB web site at www.fpmb.org. Simply press the "order reports" button. After filling out an online form, visitors have the option to immediately pay for requests with their Visa or Master Card credit card. **Alternatively, requests may be printed and mailed to the Federation of Podiatric Medical Boards with a check.**

The new FPMB mailing address is:
Larry Shane, Executive Director
Federation of Podiatric Medical Boards
6551 Malta Drive
Boynton Beach, FL 33437
(561) 752-3735

NAME: _____

ADDRESS: _____

CITY, STATE, ZIP _____

TELEPHONE: _____

STATE IN WHICH
PMLEXIS WAS TAKEN _____

DATE PMLEXIS
WAS TAKEN _____

SCHOOL & YEAR
OF GRADUATION _____

STATE BOARD TO WHICH THIS REPORT IS TO BE SENT IS LISTED ABOVE

ATTACHMENT 6

TENNESSEE BOARD OF PODIATRIC MEDICAL EXAMINERS
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

AFFIDAVIT OF ACCREDITATION OF PRECEPTORSHIP PROGRAM

If you have completed an approved Preceptorship program, please complete Section I and send this form to the college or university providing accreditation for verification.

SECTION I

_____ _____
Name of Applicant Name of Preceptorship Program

_____
Address of Preceptorship Program

_____

_____
Director of Preceptorship Program

SECTION II - THIS SECTION MUST BE COMPLETED BY AN AUTHORIZED REPRESENTATIVE OF THE COLLEGE OR UNIVERSITY PROVIDING ACCREDITATION.

This will verify that the above named Preceptorship Program has been granted full accreditation by

_____
College or University of Podiatric Medicine

_____
Name - Please Print or Type

NOTARY
SEAL

_____
Signature

_____
Title

_____
Date

Subscribed and sworn before me this _____ day of _____, _____.

(Notary Seal)

_____
Notary

ATTACHMENT 7

TENNESSEE BOARD OF PODIATRIC MEDICAL EXAMINERS
227 French Landing, Suite 300
Heritage Place MetroCenter
Nashville, TN 37243

AFFIDAVIT OF ENROLLMENT IN RESIDENCY OR PRECEPTORSHIP PROGRAM

(To Be Completed By Director)
For the Academic License of _____
Name of Applicant

Who has applied for licensure to practice as a podiatrist in Tennessee.

This is to verify that the above named applicant is currently enrolled in our residency/preceptor program.
(circle one)

_____
Signature of Director

NOTE: If the above named applicant is discharged from program or reprimanded, notify this Board immediately.

_____
Name of Director (please print)

Name and address of residency/preceptor program:

_____

_____

_____

This residency/preceptor program is approved by: _____
(circle one)

Subscribed and sworn before me this _____ day of _____, _____.

(Notary Seal)

_____
Notary Public

My commission expires _____

SP/G6112219/POD

TENNESSEE DEPARTMENT OF

HEALTH

MANDATORY
PRACTITIONER
PROFILE QUESTIONNAIRE

PURSUANT TO TENNESSEE CODE ANNOTATED SECTION 63-51-101 et seq, LAWS OF TENNESSEE

FOR

LICENSED HEALTH CARE PROVIDERS

FOREWARD

The Health Care Consumer Right-to-Know Act of 1998, T.C.A. § 63-51-101 et seq, requires designated licensed health professionals to furnish certain information to the Tennessee Department of Health. The information specified in the law is contained in the attached questionnaire. From the information submitted, the Department will compile a practitioner profile which is required to be made available to the public via the World Wide Web and toll-free telephone line after May 1, 1999. Each practitioner who has submitted information must update that information in writing by notifying the Department of Health, Healthcare Provider Information Unit, within 30 days after the occurrence of an event or an attainment of a status that is required to be reported by the law. A copy of your initial or updated profile will be furnished to you for your review prior to publication. That opportunity will allow you to make corrections, additions and helpful explanatory comments. Failure to comply with the requirement to submit and update profiling information constitutes a ground for disciplinary action against your license. A blank copy of the profile may be obtained from the following web site address: http://tennessee.gov/health.

On the department's homepage, under Licensing, click on "Health Professional Boards"; then select the appropriate board.

TABLE OF CONTENTS

SECTION I: GENERAL INSTRUCTIONS

- **Read all instructions thoroughly before completing the profile questionnaire. Incomplete or omitted information may delay meeting the mandatory reporting requirement.**
- **Incomplete or illegible profiles will be returned to the provider for resubmission.**
- **Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **Provide only information for the previous ten (10) years where indicated on the questionnaire.**
- **Complete the questionnaire and attachments by typing or printing your response in block letters in ballpoint pen. Incomplete or illegible profiles will be returned to the provider for resubmission. Some questions do not apply to every profession. If a question does not apply to you, indicate so by checking the "Does not apply" box.**
- **DO NOT RETURN THESE INSTRUCTIONS WITH THE QUESTIONNAIRE TO THE DEPARTMENT.**
- **You may have completed a similar questionnaire for another state's licensing board. If so, Tennessee law still requires you to complete and submit this form.**
- **If you have an active Tennessee license you are required to complete the questionnaire. This includes those practitioners who are retired or no longer practicing.**

- **Mail the completed ORIGINAL profile questionnaire <u>within thirty (30) days of its receipt by the provider to</u>:**

Healthcare Provider Information Manager
Tennessee Department of Health
Division of Health Related Boards
227 French Landing, Suite 300
Heritage Place Metro Center
Nashville, TN 37243
1-800-778-4123
Local - (615) 532-3202

- **<u>Keep a copy of the questionnaire for your records</u>.**

✓CHECKLIST

Before you mail your questionnaire:

Have all questionnaire and supplemental pages been completed with the name of the practitioner, profession and license number at the top of the page?

Have supplemental pages been clearly labeled with the corresponding question for which the response is being provided?

Have you retained a copy of your signed questionnaire?

SECTION II:

COMPLETING THE PROFILE QUESTIONNAIRE

QUESTIONNAIRE DEADLINE

The provider must submit the questionnaire on or before thirty (30) days from its receipt.

COMPLETING THE FORMS

Complete all forms by printing neatly in block letters in ballpoint pen or typing the information. If a question does not apply to you, indicate so by checking the "Does not apply" box. **Illegible questionnaires will be returned.**

The following numbered parts correspond to the matching number on the questionnaire form.

I. PRACTITIONER DATA

Complete part one (1) noting the following:

- License number: Fill in your license number and indicate your profession in the space provided.
- Social security number: **Your social security number will not be published or in any way given out to the public. It is required for in-house tracking purposes only.**
- Address: Complete mailing and practice address (if applicable). Retirees: Write in "N/A" for practice address.

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

List chronologically all medical/health professional related graduate/postgraduate education and training completed. Exclude any program or courses taken to satisfy continuing education requirements for licensure renewal. Provide information about health related degrees you have received including your licensure degree.

III. SPECIALTY BOARD CERTIFICATIONS

Provide information on any certification, specialty or subspecialty from any specialty board recognized by the American Medical Association, American Osteopathic Medical Association, American Podiatry Association, American Chiropractic Association, American Dental Association or any other specialty certifying body as determined by your Tennessee licensing board.

IV. FACULTY APPOINTMENTS

Answer ALL yes/no questions with a “yes” or “no” response. A brief statement in the space provided should follow a "yes" answer. If the space is insufficient for your response, attach an additional page, being sure to number the response to match the appropriate question.

V. STAFF PRIVILEGES

List all hospitals at which you hold staff privileges. This includes:

- Licensed hospitals-this term is defined at T.C.A. § 68-11-201.

In the spaces provided, answer information about the TennCare plans in which you participate, if any. If there are more than five (5), please send attachment.

VI. FINAL DISCIPLINARY ACTION

These questions refer to final disciplinary or adverse actions taken within the previous **ten (10) years**, whether in this state or any other jurisdiction. The term **final** means the matter was fully adjudicated at a hearing and the appeal’s period expired, or that the applicable board issued an agreed order or consent decree.

In the “Description of Violation” spaces, indicate the nature of the conduct in question such as malpractice, unethical conduct, drug-related, sex related, impairment, fraud, etc.

In the “Description of Action” spaces, indicate the type of disciplinary action imposed against your professional license.

The term **disciplinary action** includes, but is not limited to:

- Probation
- Limitation/Restriction
- Suspension
- Revocation
- Voluntary relinquishment in lieu of disciplinary action
- Any other adverse action taken against a license or privilege by a medical/health related institution
- Compulsory surrender of license or privilege
- Civil or other monetary fine or penalty
- Resignation from or non-renewal of medical staff membership at a hospital in lieu of, or in settlement of, a pending disciplinary case related to competence or character
- Restriction of privileges in lieu of, or in settlement of, a pending disciplinary case related to competence or character

If you answer “yes” to any of the questions in this section and if the action is under appeal, you must attach a copy of the notice of appeal. Note: You must submit a copy of the final written order of

disposition immediately after the appeal is disposed of by the adjudicating authority. Please read questions VII B and C in their entirety before answering those questions.

VII. CRIMINAL OFFENSES

This part requires you to report any state or federal felony criminal offense convictions. It also requires the reporting of misdemeanor offenses, regardless of classification, in which any element of the offense involves sex; alcohol or drugs; physical injury or threat of injury to any person; abuse or neglect of any minor, spouse or the elderly; fraud or theft in Tennessee or another jurisdiction; or unlicensed practice of a profession within the most recent ten (10) years. If you answer "yes" to this question and the offense is under appeal, you must submit a copy of the notice of appeal of that criminal offense. Immediately upon disposition of the appeal, you must submit a copy of the final written order of disposition. If any misdemeanor conviction reported is expunged, a copy of the order of expungement signed by the judge must be submitted to the Department before the conviction will be removed from any profile.

VIII. LIABILITY CLAIMS

This section requires you to indicate all medical malpractice court judgments, arbitration awards, or settlements in which a payment was awarded to a complaining party beginning with judgments or settlements entered or executed after May 19, 1998. That means if the act or event leading to the claim occurred in, for instance, 1995, but was finally adjudicated against you after May 19,1998, you must indicate that claim in the space provided. JUDGMENTS OR SETTLEMENTS BELOW THE THRESHOLD AMOUNT ESTABLISHED BY YOUR TENNESSEE LICENSING BOARD ARE NOT REQUIRED TO BE SUBMITTED. To find out the threshold amount established by your board, consult your board's web page at www.state.tn.us/health/ or call 1-800-778-4123. Pending malpractice claims are not required to be reported unless/until final adjudication against you.

IX. OPTIONAL INFORMATION

This section is voluntary. You may list, briefly describe, and submit any information/documentation regarding your professional practice in the spaces provided. Attach an additional sheet labeled with the question number if additional space is required

Practitioner's Name _____ **License #** _____
Profession _____

SECTION III:

HEALTHCARE PROVIDER INFORMATION MANAGER
TENNESSEE DEPARTMENT OF HEALTH
DIVISION OF HEALTH RELATED BOARDS
227 FRENCH LANDING, SUITE 300
HERITAGE PLACE METRO CENTER
NASHVILLE, TENNESSEE 37243

I. PRACTITIONER DATA

A. PROFESSIONAL LICENSE NUMBER:_____ PROFESSION: _____

B. SOCIAL SECURITY NUMBER: _____ (**This will not be published as part of the profile or website).**

C. NAME (INCLUDE MAIDEN AND ON 2ND/3RD LINES ANY ALIASES, IF APPLICABLE):
CURRENT NAME:

_____
(LAST) (FIRST) (MIDDLE AND MAIDEN NAME) (IF APPLICABLE)

FORMER NAME(S):

_____
(LAST) (FIRST) (MIDDLE)

_____
(LAST) (FIRST) (MIDDLE)

D. MAILING ADDRESS:

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

PRIMARY PRACTICE ADDRESS: (This will be published as part of the profile and the web site).

_____
(PRACTICE NAME)

_____
(STREET AND NUMBER)

_____
(CITY) (STATE) (ZIP CODE)

E. TELEPHONE:(____)_____ **(This will not be published as part of the profile or the web site).**

F. LANGUAGES, OTHER THAN ENGLISH: Indicate languages other than English or translation services that may be available at your primary practice location.
1. _____
2. _____

G. SUPERVISING PHYSICIAN: If you are required by law to be supervised by a physician (physician assistant or nurse practitioner) indicate the name(s) and address(es) of each supervising physician. If you need more space, attach additional sheets:
1. _____
2. _____

Practitioner's Name _____ **License #** _____
Profession _____

II. GRADUATE/POSTGRADUATE MEDICAL/PROFESSIONAL EDUCATION AND TRAINING

A. What school(s)/educational programs have you attended? And, what type(s) of degree(s) do you hold? Do not include coursework taken to meet the continuing education requirement for licensure renewal. (Authority: T.C.A. §63-51-105(a)(6) and (7))

PROGRAM/INSTITUTION	CITY/STATE/ COUNTRY	DATE OF GRADUATION	TYPE OF DEGREE
1.			
2.			
3.			
4.			
5.			
6.			

B. List in chronological order from date of graduation to the present, all completed medical/professional graduate and/or post-graduate training (internship, residency, fellowship or other program). Do not include coursework taken to meet continuing education requirements for licensure renewal. (Authority: T.C.A. § 63-51-105(a)(6))

PROGRAM AND SPECIALTY AREA (INTERNSHIP, RESIDENCY, FELLOWSHIP, ETC.)	LOCATION OF TRAINING (CITY,STATE, COUNTRY)	FROM MM/DD/YYYY	TO MM/DD/YYYY
1.			
2.			
3.			
4.			

Practitioner's Name _____ **License #** _____
Profession _____

III. SPECIALTY BOARD CERTIFICATIONS

Do you hold a certification, specialty or subspecialty from any specialty board recognized by the board regulating the profession for which you are licensed? (see instructions) (Authority: T.C.A. § 63-51-105(a)(8)) If "Yes", complete section below. YES ❒ NO ❒

CERTIFYING BODY/BOARD INSTITUTION	CERTIFICATION/SPECIALTY/SUBSPECIALTY
1.	
2.	
3.	
4.	
5.	

IV. FACULTY APPOINTMENTS

A. Have you had the responsibility for graduate medical education within the last ten (10) years? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

B. Do you currently hold a faculty appointment at a medical/health related institution of higher learning? (Authority: T.C.A. § 63-51-105(a)(10)) YES ❒ NO ❒

If "YES", list the title of the appointment and name(s) and city/state of institution(s). (Attach additional sheets, clearly labeled with this question number, if necessary.)

	TITLE	INSTITUTION	CITY/STATE
1.			
2.			
3.			
4.			

V. STAFF PRIVILEGES

A. Do you currently hold staff privileges at a hospital? (Authority: T.C.A. §63-51-105(a)(a)) YES ❒ NO ❒

If "YES", list each hospital at which you currently have staff privileges: (Attach additional sheets, clearly labeled with this question number, if necessary)

	Name of Hospital	City/State
1.		
2.		
3.		
4.		
5.		

Practitioner's Name _____ **License #** _____
Profession _____

B. Do you currently participate in any TennCare plan? (Authority: T.C.A. § 63-51-105(a)(16)) YES ❒ NO ❒
If "YES", list each plan in which you currently participate:

Name of TennCare Plan
1.
2.
3.
4.
5.

VI. FINAL DISCIPLINARY ACTION (See Instructions)

A. Within the previous ten (10) years, have you ever had any final disciplinary action taken against you by the agency regulating your license, in this state or any other jurisdiction? (Authority: T.C.A. § 63-51-105(a)(8)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of agency(s) and a brief description of the final disciplinary action(s) and stated reason(s) for taking the action. (Attach additional sheets, clearly labeled with this question number, if necessary.)

	AGENCY NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

B. Within the previous ten (10) years, have you ever had your hospital privileges revoked or involuntarily restricted for reasons related to competence or character by the hospital's governing body? (Authority: T.C.A. § 63-15-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) medical institution(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF VIOLATION	DESCRIPTION OF ACTION
1.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.				

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

C. Within the previous ten (10) years, have you ever been asked to or allowed to resign from or had any medical staff privileges restricted or not renewed by <u>any</u> hospital in lieu of or in settlement of a pending disciplinary action related to competence or character? (Authority: T.C.A. § 63-51-105(a)(4)) YES ❒ NO ❒

If "YES", list name(s) and address(es) of the hospital(s) and a brief description of the final disciplinary action(s) and stated reason(s) for the action. (Attach additional sheets, clearly labeled with this question number, if necessary)

	HOSPITAL NAME	DATE	DESCRIPTION OF ACTION
1.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

2.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

3.			

IF "YES", is this final disciplinary action under appeal? (attach copy of notice of appeal) YES ❒ NO ❒

Practitioner's Name _____ **License #** _____
Profession _____

VII. CRIMINAL OFFENSES (See Instructions)

Have you within the most recent ten (10) years, been found guilty, regardless of whether adjudication of guilt was withheld, or pled guilty or nolo contendere to a criminal misdemeanor or felony in any jurisdiction? (Authority: T.C.A. § 63-15-105(a)(1))

If "YES" briefly describe the offense(s): YES ❒ NO ❒

	DESCRIPTION OF OFFENSE	DATE	JURISDICTION
1.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
2.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒
3.			
	If "YES", is this conviction under appeal? (attach copy of notice of appeal)		YES ❒ NO ❒

VIII. LIABILITY CLAIMS

Have you had a medical malpractice court judgment, arbitration award, or settlement against you since May 19, 1998? (Authority: T.C.A. §63-51-105(a)(5)) If "YES", indicate the date of claim(s) and the amount of judgment(s), award(s) or settlement(s).

	ENTRY DATE OF DISPOSITION ORDER OR SETTLEMENT	AMOUNT
1.		
2.		
3.		

IX. OPTIONAL INFORMATION

A. PUBLICATIONS: List any publications you have authored in peer-reviewed medical literature: (optional) (Authority: T.C.A. § 63-15-105(a)(11))

	TITLE	PUBLICATION	DATE
1.			
2.			
3.			
4.			

B. PROFESSIONAL OR COMMUNITY SERVICE ACTIVITIES AWARDS: List any information regarding professional or community service associates, activities and awards: (optional) (Authority: T.C.A. § 63-15-105(a)(12))

	COMMUNITY SERVICE/AWARD/HONOR	**ORGANIZATION**
1.		
2.		
3.		
4.		

I affirm these statements are true and correct and recognize that providing false information may result in disciplinary action against my license pursuant to T.C.A. § 63-51-113 and/or 63-51-118.

_____ Date: _____

(Signature of Provider)
YB/G6019027/RTK-ms.70